| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155671 | A. BUILDING _____ B. WING _____ | R-C 12/13/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| OAKWOOD HEALTH CAMPUS | 1143 23RD ST TELL CITY, IN 47586 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 000} | INITIAL COMMENTS<br><br>This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/9/11. This visit also included the Post Survey Revisit (PSR) to the Investigation of Compliant IN00098222 completed on 11/9/11.<br><br>Complaint IN00098222- Corrected<br><br>Survey date: December 13, 2011<br><br>Facility number: 002512<br>Provider number: 155671<br>AIM number: 200278690<br><br>Survey team:<br>Terri Walters RN TC<br>Carole McDaniel RN<br>Martha Saull RN<br><br>Census bed type:<br>SNF: 22<br>SNF/NF: 69<br>Residential: 19<br>Total: 110<br><br>Census Payor type:<br>Medicare: 22<br>Medicaid: 42<br>Other: 46<br>Total: 110<br><br>Sample:14<br><br>Oakwood Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey and | {F 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| {F 000} | Continued From page 1<br>the PSR to the Investigation of Complaint IN00098222.<br><br>Quality review completed 12/14/11<br>Cathy Emswiller RN | {F 000} | | |